

SECTION 2 – PLAN AND BUDGET SUBMISSION

General Instructions

Submit one original and three copies of the CMS plan and budget package to your CMS Regional Administrative Consultant. The plan is composed of the documents that are required for submission.

Individual CCS, CHDP, and HCPCFC budgets will be approved only when all required documents have been submitted and reviewed by the appropriate regional office staff. Unless specified, counties should submit one package for all three CMS programs. The Certification Statement and Interagency Agreement, however, may be sent under separate cover after other documents have been submitted. **All pages must be numbered and dated.** After assembling the plan and budget package, complete the Checklist and include the Checklist in the plan and budget package. Fourth quarter invoices will not be paid until all documents required for approval have been submitted, reviewed, and approved.

The following are required documents of the CMS plan and budget package for Fiscal Year (FY) 2004-05:

I. Checklist (see page 2-5)

The CMS Plan and Budget Required Documents Checklist assists in identifying the contents and sequence of the documents for submission in the plan package. The contents of the package must be submitted in the sequence reflected on the checklist.

II. Agency Information Sheet (see page 2-7)

Complete the Agency Information Sheet with **all of the following**:

- A. Official name and address of the county/city agency in which the CCS, CHDP, and HCPCFC programs are organizationally located
- B. Name and contact information of the CMS Director, if any.
- C. Name and contact information of the CCS Administrator.
- D. Name and contact information of the CHDP Director.
- E. Name and contact information of the CHDP Deputy Director.
- F. Name and contact information of the Clerk of the County Board of Supervisors or City Council
- G. Name and contact information of the Director of the Social Services Agency for the HCPCFC Program
- H. Name and contact information of the Chief Probation Officer for the HCPCFC Program.

III. Certification Statement (see page 2-8)

- A. Obtain current signatures, including the dates signed, of the CHDP Director, CCS Administrator, Director/Health Officer, and the chairperson of the local governing body, as required.
- B. Submit the original Certification Statement (with signatures) and one photocopy to the Regional Office. The Certification Statement is valid for one year.
- C. The citations of current federal and state legislation and regulations for the CCS, CHDP, and HCPCFC programs are listed in Section 10 – References.
- D. An additional line for the signature of any other person with fiscal or programmatic responsibility is included for optional use.

IV. Agency Description

- A. Describe in brief narrative:
 - 1. The structure of the agencies in which CCS, CHDP, and HCPCFC programs are located; and
 - 2. The current organizational structures of the CCS, CHDP, and HCPCFC programs within the local agencies (Health and/or Social Services); and
 - 3. The affiliation and integration of the CCS, CHDP, and HCPCFC programs within the agency and county structure; and
 - 4. Anticipated changes that will take place before the next fiscal year.
- B. Submit current organizational charts for CHDP, HCPCFC and CCS with names of incumbent staff using the **same job titles** as listed on the budget worksheets.
- C. Submit a copy of the CCS Staffing Standards Profile (6-80) and highlight the caseload category for your county/city. For counties with total caseloads below 500, write the words "Below 500" at the top of the CCS Staffing Standards Profile and highlight those words only.
- D. Complete Incumbent List (see pages 2-9 through 2-11) for CCS, CHDP, and HCPCFC programs.
- E. Submit civil service classification statements for newly established, proposed, or revised classifications.
- F. Submit duty statements for all staff budgeted to the programs **if there are changes from the previous year** (see pages 2-9 through 2-11).
 - 1. Changes are defined as:
 - a. Changes in job duties or activities, or
 - b. Changes in percentage of time allotted for each activity.
 - 2. Include in the duty statement **all of the following:**

- a. Position title
 - b. Civil service classification
 - c. Percent FTE in CCS, CHDP, and/or HCPCFC program(s) and percent FTE in other program(s) if applicable
 - d. Actual job duties appropriate and specific to the CCS, CHDP, and/or HCPCFC program **with an estimated percentage of time allocated to each activity** (see Documentation of Staff and Time on page 9-4 for more information).
3. If staff work in multiple programs, submit separate job duty statements for each program.

V. Implementation of Performance Measures (see Section 3 – Scope of Work and Performance Measures)

- A. CCS, CHDP, and HCPCFC programs under joint administrations should submit joint Performance Measures when reporting to the CMS Branch.
- B. CCS, CHDP, and HCPCFC programs under separate administrations should collaborate to ensure coordination of services and resources and cooperatively submit one package when reporting Performance Measures to the CMS Branch.
- C. Performance Measures should be reported in the appropriate reporting format, except for those Performance Measures that specifically require a county tracking system.
- D. Data collection for these Performance Measures began with Fiscal Year 2002-03. **Reporting on these Performance Measures is due annually by November 30.**

VI. Data Forms

- A. Examples of Children Helped (see page 4-4) for:
 1. CCS,
 2. CHDP, and
 3. HCPCFC
- B. CCS Caseload Summary (see pages 4-5 through 4-7).
- C. CHDP Case Management Data (see page 4-8)

VII. Memoranda of Understanding (MOU) and Interagency Agreements (IAA) List (page 2-12)

- A. List all current MOUs and IAAs

- B. Submit all MOUs and IAAs that are new or have been revised since the prior fiscal year.
- C. Submit CHDP IAA with DSS biennially.
- D. Submit Interdepartmental MOU for HCPCFC biennially.

VIII. Budgets

- A. CCS Administrative Budget
 - Budget Summary
 - Budget Worksheet
 - Budget Justification Narrative
- B. CCS Medical Therapy Program (MTP) Claims Preparation Budget – **Optional**
 - Budget Worksheet
 - Budget Justification Narrative
- C. CHDP Administrative Budget (No County/City Match)
 - Budget Summary
 - Budget Worksheet
- D. CHDP Administrative Budget (County/City Match) – **Optional**
 - Budget Summary
 - Budget Worksheet
 - Budget Justification Narrative
- E. HCPCFC Administrative Budget
 - Budget Summary
 - Budget Worksheet
 - Budget Justification Narrative
- F. Foster Care Administrative Budget (County/City Match) – **Optional**
 - Budget Summary
 - Budget Worksheet
 - Budget Justification Narrative

Plan and Budget Required Documents Checklist

County/City: _____

Fiscal Year: 2004-05

	Document	Page Number
1.	Checklist	
2.	Agency Information Sheet	
3.	Certification Statement – Original and one photocopy	
4.	Agency Description	
	A. Brief Narrative	
	B. Organizational Charts for CCS, CHDP, and HCPCFC	
	C. CCS Staffing Standards Profile	
	D. Incumbent Lists for CCS, CHDP, and HCPCFC	
	E. Civil Service Classification Statements – Include if newly established, proposed, or revised	
	F. Duty Statements – Include if newly established, proposed, or revised	
5.	Implementation of Performance Measures – Performance Measures for prior fiscal year due annually by November 30.	N/A
6.	Data Forms	
	A. CCS Examples of Children Helped	
	B. CHDP Examples of Children Helped	
	C. HCPCFC Examples of Children Helped	
	D. CCS Caseload Summary	
	E. CHDP Case Management Data	
7.	Memoranda of Understanding and Interagency Agreements List	
	A. MOU/IAA List	
	B. New, Renewed, or Revised MOUs or IAAs	
	C. CHDP IAA with DSS biennially	
	D. Interdepartmental MOU for HCPCFC biennially	
8.	Budgets	
	A. CCS Administrative Budget	
	1. Budget Summary	

County/City: _____

Fiscal Year: 2004-05

	Document	Page Number
	2. Budget Worksheet	
	3. Budget Justification Narrative	
B.	CCS Medical Therapy Program Claims Preparation Budget – (Optional)	
1.	Budget Worksheet	
2.	Budget Justification Narrative	
C.	CHDP Administrative Budget (No County/City Match)	
1.	Budget Summary	
2.	Budget Worksheet	
3.	Budget Justification Narrative	
D.	CHDP Administrative Budget (County/City Match) – Optional	
1.	Budget Summary	
2.	Budget Worksheet	
3.	Budget Justification Narrative	
E.	HCPCFC Administrative Budget	
1.	Budget Summary	
2.	Budget Worksheet	
3.	Budget Justification Narrative	
F.	Foster Care Administrative Budget (County/City Match) – Optional	
1.	Budget Summary	
2.	Budget Worksheet	
3.	Budget Justification Narrative	

Agency Information Sheet

County/City: _____

Fiscal Year: 2004-05

Official Agency

Name: _____ Address: _____

CMS Director (if applicable)

Name: _____ Address: _____

Phone: _____

Fax: _____ E-Mail: _____

CCS Administrator

Name: _____ Address: _____

Phone: _____

Fax: _____ E-Mail: _____

CHDP Director

Name: _____ Address: _____

Phone: _____

Fax: _____ E-Mail: _____

CHDP Deputy Director

Name: _____ Address: _____

Phone: _____

Fax: _____ E-Mail: _____

Clerk of the County Board of Supervisors or City Council

Name: _____ Address: _____

Phone: _____

Fax: _____ E-Mail: _____

Director of Social Services Agency

Name: _____ Address: _____

Phone: _____

Fax: _____ E-Mail: _____

Chief Probation Officer

Name: _____ Address: _____

Phone: _____

Fax: _____ E-Mail: _____

Certification Statement

County/City: _____

Fiscal Year: 2004-05

The undersigned certify that (1) the statements herein are true and complete to the best of their knowledge; (2) this community's Child Health and Disability Prevention (CHDP) and California Children's Services (CCS) programs will comply with all State and federal policies and legal requirements pertaining to the CHDP and CCS programs; (3) the undersigned agree to provide the California Department of Health Services the required program reports, reports of budgets, program and personnel changes, and access to all fiscal and program records for purposes of audit and review by State and federal staff, and (4) this plan and justification is a public document as prescribed by the California Public Records Act of 1968.

Signature of CCS Administrator

Date Signed

Signature of CHDP Director

Date Signed

Signature of Director or Health Officer

Date Signed

Signature and Title of Other – Optional

Date Signed

I certify that this plan has been approved by the local governing body.

Signature of Local Governing Body Chairperson

Date

State of California - Health and Human Services Agency

Department of Health Services - Children's Medical Services Branch

California Children's Services Incumbent List

For FY 2004-05, complete the table below for all personnel listed in the CCS budgets. Use **the same** job titles for both the budget and the incumbent list. Total percent for an individual incumbent should **not be over 100 percent**.

Specify whether job duty statements or civil service classification statements have been revised or changed. This includes (1) changes in job duties or activities or (2) changes in percentage of time spent for each activity. Only submit job duty statements and civil service classification statements that are new or have been revised. Do **not** resubmit job duty statements for (1) changes in the incumbent names or (2) changes in percentage of enhanced/nonenhanced time.

Identify Nurse Liaison positions using: **MCMC** for Medi-Cal Managed Care; **HF** for Healthy Families; **IHO** for In-Home Operations, and; **RC** for Regional Center.

County/City: _____

Fiscal Year: 2003-04

Job Title	Incumbent Name	FTE % on CCS Admin Budget	FTE % on CCS MTP Claims Budget	FTE % in Other Programs (Specify)	Have Job Duties Changed? (Yes or No)	Has Civil Service Classification Changed? (Yes or No)

State of California - Health and Human Services Agency

Department of Health Services - Children's Medical Services Branch

Child Health and Disability Prevention Program Incumbent List

For FY 2004-05, complete the table below for all personnel listed in the CHDP budgets. Use **the same** job titles for both the budget and the incumbent list. Total percent for an individual incumbent should **not be over 100 percent**.

Specify whether job duty statements or civil service classification statements have been revised or changed. This includes (1) changes in job duties or activities or (2) changes in percentage of time spent for each activity. Only submit job duty statements and civil service classification statements that are new or have been revised. Do **not** resubmit job duty statements for (1) changes in the incumbent names or (2) changes in percentage of enhanced/nonenhanced time.

County/City:

Fiscal Year: 2003-04

Job Title	Incumbent Name	FTE % on CHDP No County/ City Match Budget	FTE % on CHDP County/City Match Budget	FTE % in Other Programs (Specify)	Have Job Duties Changed? (Yes or No)	Has Civil Service Classification Changed? (Yes or No)

State of California - Health and Human Services Agency

Department of Health Services - Children's Medical Services Branch

Health Care Program for Children in Foster Care Incumbent List

For FY 2004-05, complete the table below for all personnel listed in the HCPCFC and Foster Care Administrative (County/City) budgets. Use **the same** job titles for both the budget and the incumbent list. Total percent for an individual incumbent should **not be over 100 percent**.

Specify whether job duty statements or civil service classification statements have been revised or changed. This includes (1) changes in job duties or activities or (2) changes in percentage of time spent for each activity. Only submit job duty statements and civil service classification statements that are new or have been revised. Do **not** resubmit job duty statements for (1) changes in the incumbent names or (2) changes in percentage of enhanced/nonenhanced time.

County/City: _____

Fiscal Year: 2003-04

Job Title	Incumbent Name	FTE % on HCPCFC Budget	FTE % on FC Admin County/City Match Budget	FTE % in Other Programs (Specify)	Have Job Duties Changed? (Yes or No)	Has Civil Service Classification Changed? (Yes or No)

State of California - Health and Human Services Agency

Department of Health Services - Children's Medical Services Branch

Memoranda of Understanding/Interagency Agreement List

List all current Memoranda of Understanding (MOUs) or Interagency Agreements (IAAs) in California Children's Services, Child Health and Disability Prevention Program, and Health Care Program for Children in Foster Care. Specify whether the MOU or IAA has changed. Submit only those MOUs and IAAs that are new, have been renewed, or have been revised. For audit purposes, counties or cities should maintain current MOUs and IAAs on file.

County/City: _____

Fiscal Year: 2003-04

Title or Name of MOU/IAA	Is this a MOU or an IAA?	Effective Dates	Date Last Reviewed by County/City	Name of Person Responsible for this MOU/IAA?	Did this MOU/IAA Change? (Yes or No)